Mothers with Opioid Use Disorder: Moving Toward Justice, Wellness, and Engagement

by
Heather Howard* and Wendy F. Guastaferro**

In the United States, the number of children in foster care and involved in child custody conflicts between parents and caregivers has increased steadily over the past five years. A primary driver in out-of-home placements is parental substance abuse. The increase is largely attributable to the opioid crisis. High quality drug treatment and stigma reduction strategies are components of a wellness and engagement approach that would reduce the reliance on placing children in foster care. To embrace a health and wellness perspective, collaborations between family court systems and healthcare systems are necessary. This article describes the nature of substance abuse services and medication-assisted treatment for opioid use disorder and uses federal legislation to illustrate how existing policies impact mothers with opioid use disorder. Many current responses have been punitive and coercive and often involve the foster care and child custody systems. There are multifaceted policy issues that impact mothers with opioid use disorders such as barriers to treatment, mandatory reporting, and criminalization. Both inter-professional collaboration and stigma reduction strategies are models of practice for providers in both the court systems and healthcare as they promote a public health approach to substance misuse

* Heather Howard, LICSW, PhD, is an Assistant Professor at the Phyllis & Harvey Sandler School of Social Work, Florida Atlantic University and may be contacted at howardh@fau.edu. Dr. Howard is conducting a community-based study with mothers impacted by substance abuse and the child welfare system.

** Wendy Guastaferro, PhD, is an Associate Professor in the School of Criminology & Criminal Justice, Florida Atlantic University and may be contacted at wguastaferro@fau.edu. Her latest research, funded by the Administration for Children and Families, focuses on best practices for parents in family treatment courts.

rather than a moral failure perspective. This article will suggest ways for the court, treatment professionals, and legal counsel to provide coordinated and non-judgmental care.

Introduction

In the United States, family and child protection courts, lawyers, judges, guardians ad litem, forensic mental health experts, and medical and mental health professionals have struggled with the ever-increasing complexity of the opioid crisis and its impact on family stability, including intergenerational and sibling relationships.[1] In the child protection and adoption arenas this struggle with hopefulness conflicts with time lines for reunification and treatment as a predicate to parental fitness as well as policy preferences for child stability in kinship or foster care.[2] In child custody cases between private parties (and not the state), courts struggle with the impact of addiction on grandparents, guardianships, legal and physical custody, and, similarly, time lines for treatment that may conflict with child safety and stability.[3] More-

---

[1] *See* Lynn M. Paltrow, *Why Caring Communities Must Oppose C.R.A.C.K./Project Prevention: How C.R.A.C.K. Promotes Dangerous Propaganda and Undermines the Health and Well Being of Children and Families*, 5 J.L. & Soc'y' 11, 86-87 (2003) (quoting Mark Hardin, Foster Children in the Courts 206 (1983)) (""Many people in our society suffer from drug or alcohol dependence yet remain fit to care for a child.'").

[2] *See, e.g., In re* C.C.S, 904 N.W.2d 408, 409 (Wis. Ct. App. 2017) ("Under the circumstances, the circuit court found compelling reasons for denying custody to Mom and for appointing a guardian as Mom 'has been unfit or unable to care for [Johnny] or has engaged in a persistent neglect of her parental responsibilities, or suffered an extended disruption of parental custody due to her significant opiate addiction and criminal activity,' and the County had made reasonable efforts to return Johnny to Mom's care.").

[3] *See, e.g.,* Daggett v. Sternick, 109 A.3d 1137, 1140-41 (Me. 2015) ("Determining what is in the best interest of the child necessarily involves considering whether a parent's ability to care for his or her child is impaired, including by his or her marijuana use. As with any medication or substance, the question of whether a parent's ingestion of marijuana is legal is only part of the equation. The more important question is whether that ingestion negatively affects, limits, or impairs a parent's capacity to parent his or her child. Regardless of the cause, if a parent's capacity to meet the needs of his or her child is compromised, a court must consider that in assessing the best interest of the child. An impaired parent may be unable to act in the best interest of the child. This may be true regarding any medication or legal substance that a parent ingests, whether or

over, the myth that opiate addiction, from heroin to crack cocaine, only affects lower socio-economics strata in the United States is just that—a myth. There are few family systems, from urban to rural to suburban, untouched by addiction or drug use, including evolving legalization of marijuana and its impact as well on child custody and child protection proceedings.[4]

In practice this means that family practitioners, child welfare staff, and family courts may adopt the belief that serious substance misuse or disorders overwhelmingly requires the removal of children from the home and, potentially, parental termination or loss of legal and physical custody. These viewpoints are particularly "prevalent among judges, district attorneys, and court personnel, especially regarding substance-exposed newborns."[5] And these same agencies and family courts now must struggle with issues of impairment and parental marijuana use because, in part, recent changes to federal child maltreatment laws require health care providers to notify child protective services of all infants identified as affected by parental substance use, including marijuana, who in the past may not have come to the attention of an agency or court.[6] Systemic and policy barriers, thereby may "hin-

---

not the Legislature has specifically addressed the particular medication or substance through a statute.").

[4] The economic and health disparities are discussed in substantial literature. *See* Monica J. Alexander, et al., *Trends in Black and White Opioid Mortality in the United States, 1979–2015*, 29 EPIDEMIOLOGY 707 (2018).

[5] LAURA RADEL, ET AL., SUBSTANCE USE, THE OPIOID EPIDEMIC, AND THE CHILD WELFARE SYSTEM: KEY FINDINGS FROM A MIXED METHODS STUDY, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION 7 (2018); *see also* Sarah Collins, *Unreasonable Seizure: Government Removal of Children from Homes with Drugs but No Evidence of Neglect*, 20 GEO. MASON L. REV. 631, 639 (2012) ("A recent study found that approximately 9 percent of children in the United States, or six million children, live in homes where at least one parent abuses alcohol or drugs. These children are disproportionately represented in child maltreatment cases, with between one-third and two-thirds of child removal cases involving some form of substance use."); Alison Niccols, et al., *Integrated Programs for Mothers with Substance Abuse Issues: A Systematic Review of Studies Reporting on Parenting Outcomes*, 9 HARM REDUCTION J. 14, 15 (2012) ("Research has shown that women who abuse substances may have difficulties providing stable, nurturing environments for their children compounded by challenging life circumstances, including severe economic and social problems, such as lack of affordable housing and homelessness.").

[6] *Id.*

der collaboration between child welfare agencies, substance use disorder treatment programs, and courts."[7]

For clients across a wide span of socio-economic statuses, opioid and substance abuse is a frequent (if too often hidden) aspect of public and private child custody litigation.[8] Developing responses to this national emergency requires intervention at the individual, interpersonal, community, and societal levels (known in public health as the social-ecological model). This article, therefore, focuses on a particularly vulnerable population at the intersection of public health, child welfare, and the courts: pregnant and parenting women with opioid use disorder. The objective is to provide resources and research which may assist lawyers and courts with providing services to parents and children.[9] From the authors' perspective as non-lawyers, there is a significant role for the AAML in this policy area. Lawyers play a powerful role as advocates and may influence policy that helps families navigate complex family court and political systems in a way that more effectively serves the safety and stability of children.

I. Demographics and Consequences

American life expectancy has declined for the third year in a row. Life expectancy is a gauge of the nation's overall health, and

---

[7] *Id*. at 8.

[8] *See* Loretta Finnegan, et al., *New Approaches in the Treatment of Opioid Dependency During the Pregnancy*, 11 HEROIN ADDICTION & RELATED CLINICAL PROBS. 47, 48 (2009) ("In summary, perinatal opioid dependence is a problem of major public health importance for women and children throughout the world. Societal moral attitudes which have stigmatized and dehumanized women who use drugs during pregnancy have placed barriers in the way of obtaining optimal medical and obstetric care. These considerations apply to women of all races and socioeconomic status.").

[9] There are developments in evidence-based research which targets siblings and family systems. *See* John H. Bamberg, et al., *Including the Siblings of Youth Substance Abusers in a Parent-Focused Intervention: A Pilot Test of the Best Plus Program*, 40 J. PSYCHOACTIVE DRUGS 281 (2008); *see also* Natasha Slesnick, et al., *Parenting Under the Influence: The Effects of Opioids, Alcohol and Cocaine on Mother–Child Interaction*, 39 ADDICTIVE BEHAV. 897, 897 (2014) ("Taken together, by understanding factors unique to mothers based on their drug of choice (opioids, alcohol, or cocaine), race, and age of child, it will be possible to develop targeted interventions for these mothers and their children.").

opioid overdoses are a primary driver of this decline.[10] Between 1999-2017 more than 700,000 people in the United States died due to drug overdoses, more than gun and vehicular homicides combined.[11] In 2017 the number of deaths from opioid overdose was six times higher than in 1999.[12] Causes of the opioid crisis are numerous and include the pharmaceutical industry's considerable influence over policy and practice, the industry's targeted marketing to physicians, the industry's minimization of the addictive threat of painkillers, physician overprescribing followed by regulations restricting access to painkillers, the low-cost and wide availability of heroin, mixing potent and synthetic opioids (like fentanyl) with heroin, social isolation and stress, and the slow and limited treatment response.[13]

The opioid crisis has a differential impact on certain populations, particularly women of childbearing age. From 2015 to 2016, the greatest percentage increase in the drug overdose death rates occurred among adults aged 15–24, 25–34, and 35–44, with

---

10 *See* Julia Haskins, *Suicide, Opioids Tied to Ongoing Fall in US Life Expectancy: Third Year of Drop*, 49 NATION'S HEALTH 1 (2019).

11 *See* CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), UNDERSTANDING THE EPIDEMIC (2018), https://www.cdc.gov/drugoverdose/epidemic/index.html; CHRIS CHRISTIE, ET AL., PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS. FINAL REPORT (EXECUTIVE OFFICE OF THE PRESIDENT) (2017).

12 *Id*.

13 *See* Ameet Sarpatwari, et al., *The Opioid Epidemic: Fixing a Broken Pharmaceutical Market*, 11 HARV. L. & POL'Y REV. 463, 480 (2017) ("Finally, to boost profits, pharmaceutical companies have often engaged in false or misleading marketing. Over the past twenty-five years, the industry has paid $35.7 billion to settle claims of illegal marketing, including making false or misleading claims or failing to disclose known risks.); Melina Sherman, *Opiates for the Masses: Constructing a Market for Prescription (Pain) Killers*, 10 J. CULTURAL ECON. 485, 487 (2017) ("In the case of prescription opioid abuse, the whiteness of representations of addiction in popular culture is also somewhat reflective of drug use in practice. White people are doing more drugs than ever, but then again, so is everyone else. In SAMHSA's 2014 National Survey on Drug Use and Health, more people in nearly every demographic report doing more drugs than in the past: For example, approximately 27 million Americans above 11 years old reported currently using illicit drugs."). The United States is exporting this social welfare and public health disease problem. *See* Keith Humphreys, et al., *Opioids of the Masses: Stopping an American Epidemic from Going Global*, 97 FOREIGN AFF. 118 (2018).

increases of 28%, 29%, and 24%, respectively.[14] From 1999 through 2016, mortality rates for opioid overdose increased 507% among women, compared to 321% among men, according to the National Institute on Drug Abuse (2019).[15] Women experience greater adverse medical, psychological, and functional consequences associated with substance use disorder (SUD) than men.[16] Literature suggests that women experience pain differently, and are more likely to receive a prescription for chronic pain, more likely to be prescribed opioids than men, and more likely to be using additional medications that increase risk for complications and overdose.[17] Women's pathway to addiction is different and faster, and women are less likely to seek traditional substance abuse treatment than men, though it is worth noting that once engaged in treatment, men and women have similar outcomes. Barriers to treatment for women include stigma, treatment availability, and family responsibilities.[18] Relevant to this discussion, and among many fears, women also express concern over child care when explaining their hesitancy to enter treatment.[19]

Correspondingly, the incidence of pregnant and parenting women with an opioid use disorder (PPWOUD) is increasing at an alarming rate. This has led to devastating consequences, in-

---

14 *See* NATIONAL INSTITUTE ON DRUG ABUSE, OVERDOSE DEATH RATES (Jan. 2019), https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

15 *See* Sarah C. Haight, et al., *Opioid Use Disorder Documented at Delivery Hospitalization—United States, 1999–2014*, 67 MORBIDITY & MORTALITY WKLY. REP. 845 (2018); *see also* NATIONAL INSTITUTE ON DRUG ABUSE, OVERDOSE DEATH RATES (Jan. 2019), https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.

16 *See* R. Kathryn McHugh, et al., *Anxiety Sensitivity and Nonmedical Benzodiazepine Use Among Adults with Opioid Use Disorder*, 65 ADDICTIVE BEHAV. 283 (2017).

17 *See* Carolyn M. Mazure & David A. Fiellin, *Women and Opioids: Something Different Is Happening Here*, 892 LANCET 8 (2018).

18 *See* Olivia S. Ashley, et al., *Effectiveness of Substance Abuse Treatment Programming for Women: A Review*, 29 AM. J. DRUG & ALCOHOL ABUSE 19 (2003); Shelly F. Greenfield, et al., *Substance Abuse Treatment Entry, Retention, and Outcome in Women: A Review of the Literature,* 86 DRUG & ALCOHOL DEPENDENCE 1 (2007).

19 Rebecca Stone, *Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care*, 3 HEALTH & JUSTICE 2 (2015).

cluding overdose fatalities, more newborns exposed to opioids in utero and experiencing neonatal abstinence syndrome, and mothers and children separated, sometimes permanently, through the child welfare and criminal justice systems.

II. Maternal Health and Opioid Use

Women who use opioids during pregnancy face myriad health challenges, including anemia, poor nutrition, increased blood pressure, hyperglycemia, sexually transmitted diseases (STDs), hepatitis, preeclampsia, co-occurring disorders, and other complications of pregnancy or health problems related to addiction.[20] There is a risk for obstetrical complications, which are often difficult to identify because women do not want to report pregnancy-related problems out of fear of action by authorities, shame, and stigma. Given the health-related issues alone, interaction with the legal system and the capacity to access services such as legal representation may be compromised.[21] These are a few of the consequences as described below.

A. *The Effects of Stigma on Recovery*

Pregnant women who abuse drugs receive very high societal condemnation.[22] According to Stephanie Covington, stigma (i.e., severe social disapproval) is the main psychological issue differentiating substance abuse concerns of females from those of

---

20 American College of Obstetricians and Gynecologists, *Opioid Use and Opioid Use Disorder in Pregnancy. Committee Opinion No. 711*, 130(2) OBSTETRICS & GYNECOLOGY 81 (2017).

21 For a particularly powerful view, see Vicki Lens, *Judging the Other: The Intersection of Race, Gender, and Class in Family Court*, 57 FAM. CT. REV. 72, 78 (2019) ("More often than not the narratives constructed by the legal and social work professionals were of blame, helplessness, and dependency, with parents' as objects to be molded and rehabilitated. Since most of the respondents were women, gender was always a subtext, as they were accused of violating the sanctity of motherhood and dominant beliefs about what constituted good mothering. There was little time or room for drawing out the complexity of the parents' lives, which were reduced to the sum of a negative act, rather than the complex whole. And while most parents remained silent as narratives were constructed, some resisted, albeit unsuccessfully, to shift them.").

22 Norma Finkelstein, *Treatment Issues for Alcohol- and Drug-Dependent Women*, 19 HEALTH & SOCIAL WORK 1 (1994).

males.[23] Furthermore, substance dependent women often internalize this stigma and experience guilt, shame, despair, and fear. Carolyn Carter addressed the stigmatic and societal attitudes toward perinatal drug abuse.[24] For example, treatment providers may assume that a pregnant woman who is also misusing prescription painkillers would be an unsuitable parent, and when referred to child welfare authorities, her drug use becomes a legal issue. This moral construction blames the mother as the responsible party, rather than assessing social resources that would enable safe parenting and recovery from addiction.

This fundamental attribution error assigns problems exclusively to the disposition and behavior of the pregnant patient and ignores contextual and environmental factors. It does not acknowledge potential strengths that the woman may have. It is well documented that some providers' deeply held cultural beliefs and stigma commonly result in punitive responses toward pregnant women who are opioid dependent.[25] Carter suggests that perinatal care for women who are addicted be less a legal issue (i.e., Child Protective Service involvement) and more of a health issue.[26]

Stigma is present for the pregnant woman even when she is on medication-assisted treatment. This construct has the potential to become a reality with no alternative perspectives possible. For example, in spite of its initial philosophy of a "temporary harm reduction" intervention, medication-assisted treatment (MAT) appears to be administered for an indefinite period, and this practice can essentially label the woman throughout the pregnancy and postpartum period as an "addict." Additionally, there is a difference of opinion concerning MAT and whether it is in fact an acceptable treatment choice for some, or whether it is at best a temporary treatment choice that should be ended as

---

23 Stephanie Covington, *Helping Women Recover: Creating Gender-Responsive Treatment,* THE HANDBOOK OF ADDICTION TREATMENT FOR WOMEN: THEORY AND PRACTICE 1, 1-17 (2002).

24 Carolyn S. Carter, *Perinatal Care for Women Who Are Addicted: Implications for Empowerment*, 27 HEALTH & SOC. WORK 166 (2002).

25 Martha L. Velez & Lauren Jansson, *The Opioid Dependent Mother and Newborn Dyad: Nonpharmacologic Care*, 2 J. .ADDICTION MED. 113 (2008).

26 *See* Covington, *supra* note 23, at 2.

rapidly as possible.[27] The status of "drug dependent" can influence and affect medical and social treatment of PPWOUD and their future children.

In addition, gender-specific social expectations of women certainly exist. If a pregnant woman is noncompliant with the recommended substance-abuse treatment and prenatal care, she may be considered an inadequate parent, an inadequate person, and eventually, an inadequate woman. The woman is stigmatized as an immoral and deficient parent, first for being opioid dependent, and then for being on MAT. All of this has the potential for shaping the woman's self-worth and her ability to make informed choices about her treatment, whether for addiction or pregnancy, and with whom she may choose to have authentic conversations and in whom she may confide. What would these women say about perceived allies and supports during their prenatal and postpartum care? If child welfare does become involved who are allies as they interface with family court systems?

It is important to consider the contextual factors that occur for pregnant and parenting women with a substance use disorder because that context influences biases and the roles of professionals in courts or other institutions. The theory of "social constructionism" is helpful in understanding the complexities of the multiple systems impacting the mother with opioid use. Social constructionism stresses the social aspects of understanding the influence of cultural, historical, political, and economic conditions.[28] Specifically, medical practice categories and assumptions are fluid and are influenced continuously by the communities people belong to, varying across cultures and throughout history.[29] Many present theories of inequality in health care fall under the broad canopy of social constructionism. People in power are able to determine the definitions and categories that are used, such as "standards of care" in medical practice and child welfare systems. Social constructionism challenges the idea

---

27 Heather Howard, *Reducing Stigma: Lessons from Opioid Dependent Women*, 26 J. Soc. Work Prac. in the Addictions 418 (2015).

28 Ruth G. Dean, *Constructivism: An Approach to Clinical Practice*, 63(2) Smith College Stud. Soc. Work 127 (1993).

29 *Id.* For a comprehensive analysis of this history, see Beyond Economic Man: Feminist Theory and Economics (Marianne A. Ferber & Julie A. Nelson, eds., 1993).

of a single "truth" and the "facts" of the dominant power's discourse.[30]

A critical feminist perspective within a social constructionist framework enables researchers and policy makers to examine potential issues of racism, classism, and sexism in the policies, practices, and structures of obstetrical medicine.[31] Merlinda Weinberg explored the dominant discourse in a prenatal care setting and how it suggests what is acceptable and normative in mothering practices in the medical community.[32] Drug use is not seen as normative and evokes strong reactions by medical providers, and child welfare workers. As such, the PPWOUD may live in secrecy or continual anxiety trying to manage the shame she perceives from medical providers and social workers.[33] In fact, a recent study with adults who misuse substances, demonstrated decreased support and perceived stigma is correlated to increased mental health concerns and continued substance use.[34]

B. *Compassionate Care*

The comorbidity of trauma and substance use is well documented in the scientific literature. A meta-analysis conducted to estimate substance use rate found higher rates in those with trauma compared to those without trauma.[35] Women who experience childhood sexual abuse are more likely to use substances

---

30 *See generally* KENNETH J. GERGEN, AN INVITATION TO SOCIAL CONSTRUCTION (3d ed. 2015).

31 *See* Patricia Arredondo & Daniel C. Rosen, *Applying Principles of Multicultural Competencies, Social Justice, and Leadership in Training and Supervision*, *in* ADVANCING SOCIAL JUSTICE THROUGH CLINICAL PRACTICE (Etiony Aldarondo ed., 2007).

32 *See* Merlinda Weinberg, *Pregnant with Possibility: The Paradoxes of "Help" as Anti-oppression and Discipline with a Young Single Mother*, 87 FAM. IN SOC'Y 161 (Apr. 2006).

33 *See* SUSAN P. ROBBINS ET AL., CONTEMPORARY HUMAN BEHAVIOR THEORY: A CRITICAL PERSPECTIVE FOR SOCIAL WORK (3d ed. 2011).

34 *See* Sasha Cooper, et al., *Perceived Stigma and Social Support in Treatment for Pharmaceutical Opioid Dependence*, 37 DRUG & ALCOHOL REV. 262 (2018).

35 Merith Cosden, et al., *Trauma Symptoms for Men and Women in Substance Abuse Treatment: A Latent Transition Analysis*, 50 J. SUBSTANCE ABUSE TREATMENT 18 (Sept. 2015).

and require gender-specific treatment.[36] Pregnant and postpartum women with substance use disorders have the potential for re-traumatization in environments such as healthcare and family courts and necessitate a trauma-informed approach.

In a qualitative health study, the two fears PPWOUD expressed were having their infant removed from their custody by Child Protective Services (CPS) and their infant having Neonatal Abstinence Syndrome.[37] This stress-laden environment amidst the perinatal and postpartum period has the potential to impact a mother's mental health and long-term recovery. It is unknown how infant removal by child welfare impacts recovery, specifically relapse and posttraumatic stress disorder. In a longitudinal study on custodial status for women with substance use, 60% of the women who received integrative treatment had longer recovery time from alcohol and drugs, secure housing, and support for staying sober, and retained custody at the end of the study.[38] Including infants as part of a woman's recovery process and recognizing the importance of attachment to their infants is a motivation for long-term recovery.[39]

As parents with opioid use disorders have increased, the number of infants and children in foster care has increased,[40]

---

36 CENTER FOR SUBSTANCE ABUSE TREATMENT, CSAT TREATMENT IMPROVEMENT PROTOCOLS (2014); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., TRAUMA-INFORMED CARE IN BEHAVIORAL HEALTH SERVICES (2014); Cosden, et al., *supra* note 35; Amanda L. Giordano, et al., *Addressing Trauma in Substance Abuse Treatment*, 60(2) J. ALCOHOL & DRUG EDUC. 55 (2016); Isabelle A. Linden, et al., *Addiction in Maternity: Prevalence of Mental Illness, Substance Use, and Trauma*, 22 J. AGGRESSION, MALTREATMENT & TRAUMA 1070 (2013); Ashley E. Sanford, et al., *Consumer Perceptions of Trauma Assessment and Intervention in Substance Abuse Treatment*, 47 J. SUBSTANCE ABUSE TREATMENT 233 (2014).

37 *See* Heather Howard, *Experiences of Opioid Dependent Women in Their Prenatal and Postpartum Care: Implications for Social Workers in Health Care* 31 J. SOC. WORK IN HEALTH CARE 1 (2015).

38 *See* Therese Grant, et al., *Maternal Substance Abuse and Disrupted Parenting: Distinguishing Mothers Who Keep Their Children from Those Who Do Not*, 33 CHILD. & YOUTH SERVS. REV. 2176 (2011).

39 *See* Edward Kruk & Parveen S. Banga, *Engagement of Substance-Using Pregnant Women in Addiction Recovery*, 30 CAN. J. COMMUNITY MENTAL HEALTH 79 (Apr. 2011).

40 Kay Nolan, *Foster Care: Can the System Handle Soaring Demand?*, 28 CQ RESEARCHER 609, 612 (July 20, 2018).

hence decreasing overall resources to serve families. Therefore, there is a need for continued research regarding the use of stigma reduction strategies and trauma-informed, gender-specific policy practices to support families impacted by substance use. Peer support specialist and home-based infant mental health services are an ideal model for delivering trauma-informed, gender-specific that reduces stigma in PPWOUD.

C. *Barriers to Effective Treatment and Service Provision*

Medication-assisted treatment (MAT) has been the gold standard of treatment for opioid use disorder since the early 1970s.[41] Likewise, MAT (methadone or buprenorphine) is the gold standard of care specifically for PPWOUD. A Cochrane review of four clinical trials regarding buprenorphine versus methadone with PPWOUD found a 30-40% dropout rate for PPWOUD in MAT. Dropout rates were higher for those receiving buprenorphine than methadone, suggesting the need for additional supports to improve treatment retention.[42] This suggests the need for increased support for office-based opioid treatment (OBOT) providers in coordination of services and integration of medical and behavioral health services. Bayla Ostrach & Catherine Leiner explored perinatal substance use treatment experiences from patient and OBOT prenatal provider perspectives.[43] The study participants identified the importance of supportive care, their concern of child welfare involvement if a patient is on MAT, and the importance of care coordination to link to and prevent duplication of services as major themes that impact care. Rural providers addressed the consequences of interrupted care due to patients losing Medicaid coverage 60 days postpartum.

---

41 *See* Julie Netherland, et al., *Factors Affecting Willingness to Provide Buprenorphine Treatment*, 36 J. Substance Abuse Treatment 244 (2009); Substance Abuse & Mental Health Servs. Admin., *National Survey of Substance Abuse Treatment Services* (2017) [hereinafter *National Survey of Substance Abuse Treatment Services*].

42 *See* Silvia Minozzi, et al., *Maintenance Agonist Treatments for Opiate Dependent Pregnant Women*, 12 Cochrane Database Systematic Rev. 22 (2013).

43 *See* Bayla Ostrach & Catherine Leiner, *Experiences of Perinatal Substance Use Treatment in Western North Carolina* (University of North Carolina Sept. 13, 2018), https://sys.mahec.net/media/pressarticles/Perinatal%20SUD%20Research%20Brief.pdf.

D. *Fetal and Neonatal Health and Opioid Use*

Neonatal abstinence syndrome (NAS) is a withdrawal syndrome experienced by some opioid-exposed infants after birth. The rates of NAS increased from 3.2 to 14.5 per 1000 births based on county level data from eight states between 2009 and 2015 covering more than six million births. According to this study investigating economic and other factors associated with NAS, counties with a shortage of mental health providers were associated with higher incidence of NAS. In addition, county macroeconomic conditions affect rates of NAS especially in rural counties demonstrating health disparities.[44] As a social and policy matter, costs are extraordinarily high as a result of neonatal care units and long-term care, even before calculating costs over the life span of the child who may have complex medical and mental health requirements.[45]

There is a range of health-related problems for the infants of mothers who have untreated opioid use disorder, including low birth weight, birth defects, mental and emotional problems, and neonatal opioid withdrawal syndrome. Opioid use may affect mother-infant attachment.[46] Fetal opioid exposure and the frequently resulting consequence of neonatal withdrawal are central to the discussion of opioid addiction treatment during pregnancy. According to a nationwide study conducted from 2003 to 2008, the number of neonates diagnosed with neonatal abstinence syndrome more than doubled to almost 12,000 per year during the

---

44 *See* Stephen W. Patrick, et al., *Association Among County-Level Economic Factors, Clinician Supply, Metropolitan or Rural Location, and Neonatal Abstinence Syndrome*, 321 JAMA 385 (2019).

45 *See* NURSE-FAMILY PARTNERSHIP, THE OPIOID EPIDEMIC AND NEONATAL ABSTINENCE SYNDROME (2018), https://www.nursefamilypartnership.org/wp-content/uploads/2018/10/NFP-and-Opioids_20181030-1.pdf ("NAS introduces a significant burden on hospitals and neonatal intensive care units: in 2012, an infant with NAS had a mean hospital stay of 16.9 days and a mean hospital charge of $66,700, compared to 2.1 days and $3,500 for a term infant without complications. In 2014, Medicaid covered 82 percent of NAS births, up from 73.7% of NAS births in 2004, and over the same period total hospital costs for NAS births that were covered by Medicaid increased from $65.4 million to $462 million.").

46 *See* Nora D. Volkow, *Opioids in Pregnancy*, 352 BMJ 19 (2016).

review period.[47] The symptoms, which may appear between one and ten days after birth, include feeding problems, congestion, dehydration, fever, vomiting, diarrhea, muscle stiffness, difficulty sleeping, tremors, inconsolable crying, and sometimes seizures.[48] These symptoms typically lead to extended lengths of stay for neonates and potentially interrupt maternal–infant bonding; further, the cost of hospitalization historically has been higher for these neonates.[49]

As high as 94% of neonates exposed to opioids in utero develop neonatal abstinence syndrome.[50] The treatment of neonates with abstinence syndrome cost $640–$800 million in hospital charges in the United States in 2009; the mean charges per infant were $53,400, primarily because the hospital stays were in neonatal intensive care units.[51] In the United States between 2000 and 2009, newborns with NAS were more likely than all other births to have low birthweight (19.1%), respiratory complications (30.9%), and to be covered by Medicaid (78.1%).[52] Recently, best practices have supported rooming-in for neonates, which increases the mother-infant bond.[53] Additionally, bedside assessments for NAS have demonstrated a decreased proportion of infants receiving pharmacotherapy for NAS.

E. *Substance Abuse Treatment Providers*

This section will describe the nature of substance abuse treatment providers, the nature of substance abuse treatment ser-

---

47 Jean Y. Ko, et al., *Incidence of Neonatal Abstinence Syndrome - 28 States, 1999–2013*, 65 Morbidity & Mortality Wkly. Rep. 799 (2016).

48 *Neonatal Drug Withdrawal*, 101 Pediatrics 1079 (1998); Ann Kellogg, et al., *Current Trends in Narcotic Use in Pregnancy and Neonatal Outcomes*, 204 Am. J. Obstetrical Gynecology 359 (2011).

49 Tatiana M. Doberczak, et al., *Relationships Between Maternal Methadone Dosage, Maternal-Neonatal Methadone Levels, and Neonatal Withdrawal*, 81 J. Obstetrics & Gynecology 936 (1993); Kellogg, et al., *supra* note 48, at 259.

50 *See* Ursula A. Pritham, et al., *Methadone and Buprenorphine: Treatment During Pregnancy*. 11 Nursing for Women's Health 560 (2007).

51 Stephen W. Patrick, et al., *Neonatal Abstinence Syndrome and Associated Health Care Expenditures*, 307 JAMA E1-7 (2012).

52 *Id*.

53 *See* Lauren Sanlorenzo, et al., *Neonatal Abstinence Syndrome: An Update*, 30 Current Opinions in Pediatrics 182 (2018).

vices, medication-assisted treatment, the Child Abuse Prevention and Treatment Act (CAPTA), and the Comprehensive Addiction Recovery Act (CARA). The annual National Survey of Substance Abuse Treatment Services (N-SSATS) provides data on the location, characteristics, and types of all known treatment providers in the United States, the District of Columbia, and other U.S. jurisdictions. N-SSATS is the most reliable measure of the census and characteristics of providers in the country. There were 13,585 facilities treating 1.35 million clients on March 31, 2017, a 19% increase over ten years. The majority of clients (89%) are served by private organizations (53% not-for-profit and 36% for-profit). Interestingly, there was a 5% decrease in not-for-profit providers and a 7% increase in for-profit providers from 2016 to 2017 responding to the survey.[54] Just over half of the facilities (53%) receive government funding to provide treatment services. Ninety percent of facilities accept cash payments, 70% accept private insurance, 64% accept Medicaid, and 35% accept Medicare.

F. *Nature of Substance Abuse Treatment Services*

Nearly all facilities (80-90%) provide SUD screening and assessment, drug or alcohol urine screening, the clinical approaches of substance abuse counseling and relapse prevention, case management, discharge planning, and aftercare services. Half of the facilities (53%) provide mental health services and 44% provide medications for psychiatric disorders.[55] Of the 13,585 facilities, just 22% provide services specifically tailored for pregnant or postpartum women.

The federal government provides Substance Abuse Prevention and Treatment (SAPT) Block Grants to all fifty states, Washington D.C., and U.S. territories. Pregnant women must be given priority in treatment admissions, and those who are referred to the state for treatment must be placed in a program or have interim arrangements made within 48 hours. Further, states are required to allocate a dedicated amount of SAPT Block

---

54 *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *Data on Substance Abuse Treatment Facilities, National Survey of Substance Abuse Treatment Services (N-SSATS)* (2018).

55 *Id.*

Grant funds to support pregnant and parenting women.[56] SAPT Block Grant funding, however, has remained relatively flat and not kept pace with rising health care costs, thus diluting the actual value of funding dollars.

G. *Medication-Assisted Opioid Treatment*

Methadone and buprenorphine are federally approved medications included in the treatment guidelines for pregnant women recently updated by the Substance Abuse and Mental Health Services Administration.[57] There is insufficient information about the long-term safety of a third medication, naltrexone, for pregnant women and their infants. Generally, however, these medications are highly effective when included as part of a comprehensive treatment plan, though there are significant risks for anyone using them if the medications are not carefully prescribed and monitored. Therefore, by law, facilities need federal certification as an opioid treatment program (OTP) and must receive recertification either every 12- or 36-months to prescribe these medications for opioid use disorder.

OTPs are not limited in the types of medication they can dispense: "Of all 13,585 substance abuse treatment facilities, 10 percent (1,317 facilities) had OTPs, 29 percent (3,900 facilities) offered buprenorphine for medication-assisted opioid therapy, and 24 percent (3,197 facilities) offered injectable naltrexone for medication-assisted opioid therapy."[58] The limited availability of MAT providers can be attributed to these regulations and affiliated billing challenges, though a deeper discussion of these particular issues is beyond the scope of this paper. In addition, traditional substance abuse treatment is rooted in the twelve-step model that has historically resisted incorporating medications into treatment, further limiting the number of certified providers.

---

56 National Association of State Alcohol and Drug Abuse Directors, Substance Abuse Prevention and Treatment (SAPT) Block Grant (2017), http://nasadad.org/wp-content/uploads/2017/03/SAPT-Block-Grant-Fact-Sheet-5.9.2017.

57 *See* Substance Abuse & Mental Health Servs. Admin. (SAMHSA), *Healthy Pregnancy Healthy Baby Fact Sheets*, SMA18-5071 (2018).

58 *National Survey of Substance Abuse Treatment Services*, *supra* note 41, at 31.

Buprenorphine has unique pharmacological properties that reduce the potential for misuse. In 2002 the FDA approved buprenorphine for clinical use, thus opening the opportunity for physicians to provide MAT. Because buprenorphine is a narcotic, it is heavily regulated by the federal Controlled Substances Act. Therefore, the federal government strictly regulates the physician eligibility and certification process. Physicians may treat 30, 100, or 275 patients at a time. In mid-2019, there were 67,596 certified physicians and 74% are certified to treat 30 patients at a time.[59] These regulations both provide safeguards and inhibit the expansion of MAT in office-based settings. The federal legislation, the Comprehensive Addiction and Recovery Act (CARA), enacted in 2016, expanded prescribing authority for buprenorphine to nurse practitioners and physician assistants who are certified and receive a waiver, which may expand access to treatment.[60]

H. *Polysubstance Use and Pregnant Women*

The dramatic rise in nonmedical use of opioids by women of reproductive age has been accompanied by an increase in nonmedical opioid use in pregnant women, who have seen an increase in adverse pregnancy and birth outcomes. More than 200,000 women who were pregnant were asked about their nonmedical use of opioids (defined as use of opioid pain reliever that was not prescribed, used to get high, or heroin use) over a ten-year period.[61] from 2005-2014. Just under 23,000 (11%) reported nonmedical use of opioids while pregnant. Of these nearly 23,000 women, half also reported having more than five alcoholic drinks in one day in the past month, one-third reported marijuana use, and nearly a quarter (22.2%) reported using tranquilizers or sedatives.[62] Polysubstance use is common in women who are

---

59 *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *Physician and Program Data* (2019), https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/practitioner-program-data.

60 *See* Comprehensive Addiction and Recovery Act of 2016. Pub. L. No. 114-198, 130 Stat. 695 (2016).

61 *See* CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY. BEHAVIORAL HEALTH TRENDS IN THE UNITED STATES: RESULTS FROM THE 2014 NATIONAL SURVEY ON DRUG USE AND HEALTH (HHS PUBLICATION NO. SMA 15-4927, NSDUH SERIES H-50) (2015), http://www.samhsa.gov/data/.

62 *See* CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY, BEHAVIORAL HEALTH TRENDS IN THE UNITED STATES: RESULTS FROM THE 2014

pregnant and using opioids. Polysubstance use poses health risks, pregnancy complications, and importantly, a pressing treatment issue for these women.

I. *Policies that Facilitate and Inhibit Treatment*

Treatment recommendations can be influenced by federal mandates and state-specific laws regarding substance use in pregnancy that pose punitive measures to the mother–infant dyad. Pregnant women with substance use disorders risk intersection with the child welfare and criminal justice systems when seeking pre- or post-natal care.[63] These legal implications and their association with mental health and substance use are understudied. According to the Guttmacher Institute in 2018, 23 states and the District of Columbia consider substance use during pregnancy to be child abuse under civil welfare statues and 3 consider it grounds for civil commitment. Also, 24 states and the District of Columbia require health care professionals to report suspected prenatal drug use, and 8 states require them to test for prenatal drug exposure if they suspect drug use. In some cases, these policies apply to alcohol use as well.[64] How suspicion of drug use is determined is not well-known and involves the discretion of the provider. The test results may be used in custody or other child welfare proceedings.[65]

The American College of Obstetricians and Gynecologists and the American Society of Addiction Medicine oppose mandatory testing or reporting of substance use during pregnancy, citing the harmful effects on the mother and infant. The relationship between states with punitive policies, types of treatment available, and willingness to seek treatment needs further examination. One study found that MAT, the gold standard of

---

National Survey on Drug Use and Health (HHS No. SMA 15-4927, NSDUH Series H-50) (2015), http://www.samhsa.gov/data/.

63 *See* Cara Angelotta, et al., *A Moral or Medical Problem? The Relationship Between Legal Penalties and Treatment Practices for Opioid Use Disorders in Pregnant Women*, 26 Women's Health Issues 595 (2016).

64 *See* Guttmacher Institute, *Substance Use During Pregnancy* (Apr. 1, 2019), https://www.guttmacher.org/print/state-policy/explore/substance-use-during-pregnancy.

65 *See* Darla Bishop, et al., *Bridging the Divide White Paper: Pregnant Women and Substance Use: Overview of Research & Policy in the United States* (2017), https://hsrc.himmelforb.gwu.edu/sphhs_centers_jacobs/5/.

care for OUD, was used less frequently in states that permit child abuse charges for illicit drug use during pregnancy. MAT was used in one-third of admissions in punitive states compared with half of admissions in states without such punitive directives.[66]

Removing an infant from a mother's care may be detrimental to the infant's mental health, which suggests that building maternal capacity should be a priority. Attachment disorders can lead to significant emotional, social, and academic issues later in children's lives and possibly developing substance use disorders themselves.[67] A meta-analysis of the factors associated with mothers who use substances found that mothers with negative outcomes (e.g., lost care of their children) reported less family support, more social isolation, and fewer interpersonal resources.[68] A systematic review regarding factors associated with substance use treatment retention by pregnant women recommended gender-specific treatment which helps mothers keep their infants.[69] The review suggests current punitive approaches to substance use in pregnancy are not evidence-based and may deter treatment-seeking behavior.[70] For example, there are many challenges that arise regarding urine toxicology screens. In many cases there is not a formal written consent process where patients are fully informed. A best practice would be to fully inform women about potential consequences of a urine toxicology screen and for both patients and providers to be aware of the intended purpose of a urine toxicology screen and possible adverse outcomes such as a prohibition to breastfeed, child welfare involvement, and potential infant removal.

---

66 Angelotta, et al., *supra* note 63, at 598.

67 *See* Rebecca G. Mirick & Shelley A. Steenrod, *Opioid Use Disorder, Attachment, and Parenting: Key Concerns for Practitioners*, 33 CHILD & ADOLESCENT SOC. WORK J. 547 (2016).

68 Martha Canfield, et al., *Maternal Substance Use and Child Protection: A Rapid Evidence Assessment of Factors Associated with Loss of Child Care*, 70 CHILD ABUSE & NEGLECT 11 (2017).

69 Cosden, et al., *supra* note 35, at 19-20.

70 *See* Marlys Staudt, *Best Practices for Enhancing Substance Abuse Treatment Retention by Pregnant Women*, 14 BEST PRAC. IN MENTAL HEALTH 48 (2018).

J. *Federal Policies*

Research findings and professional recommendations support changing the American approach to care for women with SUD who are pregnant or postpartum. However, this country's historic approach to drug use as a moral failure and toward women who do not conform to the ideals of motherhood as delinquent parents result in policies that incentivize mandatory testing and reporting and punish women. In addition to the state-specific policies mentioned above, since 2003 the Child Abuse Prevention and Treatment Act (CAPTA) has mandated states submit a description of:

> policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to—
>
> > I. establish a definition under Federal law of what constitutes child abuse or neglect; or
> >
> > II. require prosecution for any illegal action.[71]

Importantly, CAPTA does not define "substance abuse" or "withdrawal symptoms resulting from prenatal drug exposure" and does not require states to respond punitively though many have opted to do so. This ambiguity has led to variations across states and inconsistent definitions and standards. For example, in some states if there are signs of exposure to illicit substances found in an infant, or if there is a positive toxicology report, there is a presumption of child abuse or neglect.[72] To be sure, CAPTA also provides funding for needed services and research, requires multi-agency collaboration and more comprehensive training of child protective services personnel, and includes a mandate to inform individuals during the first contact of the nature of complaints against them.[73] While CAPTA does not specif-

---

71 42 U.S.C. § 106(b)(2)(ii) (2018).

72 Bishop, et al., *supra* note 65, at 48.

73 For a thorough review of this legislation, see NATIONAL CHILD ABUSE AND NEGLECT TRAINING AND PUBLICATIONS PROJECT, THE CHILD ABUSE

ically define a "plan of safe care," CARA amended the CAPTA state plan requirement at section 106(b)(2)(B)(iii)(1) to require that a plan of safe care address the health and substance use disorder treatment needs of the infant and affected family or caregiver:

> We want to highlight that this change means that a plan of safe care must now address not only the immediate safety needs of the affected infant, but also the health and substance use disorder treatment needs of the affected family or caregiver. Consistent with good casework practice, the plan should be developed with input from the parents or other caregivers, as well as any collaborating professional partners and agencies involved in caring for the infant and family.[74]

III. Toward Justice, Wellness, and Engagement

Punitive measures associated with violating laws prohibiting possession of controlled substances, such as fines, loss of a driver's license, and incarceration, apply across the population. In addition, laws and policies that subject pregnant women who use substances to extra scrutiny have ramifications related to parenting rights and responsibilities, including court-ordered separation of mothers from their children. When a pregnant woman's drug test results or evidence of drug or alcohol exposure in a newborn are used in child welfare proceedings, the stated reason may be protection of the child; however, there is no requirement to show that the woman's use of a drug has caused actual or potential harm to the child.[75]

PREVENTION AND TREATMENT ACT: 40 YEARS OF SAFEGUARDING AMERICA'S CHILDREN (2014).

74 *See* U.S. DEP'T OF HEALTH & HUM. SERVS., PLANS OF SAFE CARE – ADMINISTRATION FOR CHILDREN AND FAMILIES (2017), https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf. See also 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which "increases funding for residential treatment programs for pregnant and postpartum women. The bill also requires the CDC to develop educational materials for clinicians to use with pregnant women for shared decision-making regarding pain management during pregnancy." Pub. L. No. 115-271, 132 Stat. 3894 (2018).

75 For a review of the literature, see Hamisu M. Salihu, et al., *National Trends in Maternal Use of Opioid Drugs Among Pregnancy-Related Hospitalizations in the United States, 1998 to 2009*, 32 AM. J. PERINATOLOGY 289 (2015); Valerie E. Whiteman, et al., *Maternal Opioid Drug Use During Pregnancy and*

Furthermore, a diagnosis of NAS does not equal harm or abuse to a child; for an infant born to a woman who was prescribed MAT during her pregnancy, NAS is a side effect of a medication that was being used appropriately to treat a SUD.[76] The laws and policies that apply this pregnancy-specific scrutiny to a woman's substance use have critical implications for questions that are central to debates over women's rights, including what interest, if any, the state has in protecting a fetus and at what point in pregnancy; and whether there is any legal, public health, or other justification for treating the interests of a pregnant woman as distinct from the interests of her child.

While it is known that clients, as parents, face a host of issues stemming from stigma and past trauma and compounded by the multiple ecological and environmental stressors they encounter daily, healthcare providers, attorneys and child welfare workers do not know how to comprehensively target the unique physiological, emotional, gender, and cultural needs of pregnant and parenting women facing substance use disorders. With the increased prevalence of women of childbearing age experiencing opioid use disorders, there is a critical need to develop innovative and collaborative approaches within the family courts, public health, and child welfare sectors. Coordinated care within public health, child welfare, and family court systems would enhance linkage to MAT and retention that attend to the social determinants of health and utilize a stigma-reduction theoretical approach.

In a supportive non-judgmental approach, attorneys working with mothers with OUD may ask key questions of their clients. Some important questions are: What is your safety plan if

---

its Impact on Perinatal Morbidity, Mortality, and the Costs of Medical Care in the United States, 2014 J. PREGNANCY 1.

76 *See generally* Enrique Gomez-Pomar & Loretta P. Finnegan, *The Epidemic of Neonatal Abstinence Syndrome, Historical References of Its Origins, Assessment, and Management*, 6 FRONTIERS IN PEDIATRICS 33 (2018); Enrique Gomez-Pomar, et al., *Simplification of the Finnegan Neonatal Abstinence Scoring System: Retrospective Study of Two Institutions in the USA*, 7 BMJ OPEN (2017); John J. McCarthy, et al., *Opioid Dependence and Pregnancy: Minimizing Stress on the Fetal Brain*, 216 AM. J. OBSTETRICS & GYNECOLOGY 226 (2017); Julee Oei & Kei Lui, *Management of the Newborn Infant Affected by Maternal Opiates and Other Drugs of Dependency*, 43 J. PEDIATRICS & CHILD HEALTH 9 (2007).

you are considering using opioids? Who can you call for support when you are stressed? Who is a person you can call that would provide a safe place for your infant? Many communities, such as Rebel Recovery Palm Beach County, have peer support specialists or peer recovery coaches available regardless of insurance coverage. In addition, many communities have Healthy Families America services for parents which is another evidence-based intervention for mothers and young children in need of support. This approach uses an infant mental health home-based model to improve the attachment of the mother-infant dyad and emotional well-being of the infant. Another helpful online resource is the National Center on Substance Abuse and Child Welfare which promotes safety, permanency, wellbeing, and recovery outcomes for children and their families.[77]

It is crucial to provide a non-judgmental approach and be familiar with the resources that promote positive attachment between the mother and infant. Interprofessional collaboration is essential to promote family preservation. It is our observation, so articulately stated by Professor Vicki Lens, that, "Adversarial procedures designed to protect can exclude rather than amplify voices. The lawyer–client relationship is a hierarchical one, with lawyers holding the reins of what story to tell and how to tell it. Class and race can complicate even the most well-intentioned lawyer's choices."[78] By considering these factors, across socio-economic status but recognizing the impact of the opioid crisis, lawyers can play a positive and powerful role for families caught in the family court system, as well as the funding and delivery of appropriate services for those families.

---

77 U.S. Dep't of Health & Hum. Servs., National Center on Substance Abuse and Child Welfare, https://ncsacw.samhsa.gov/ (last visited Apr. 15, 2019).

78 Lens, *supra* note 21, at 83.